STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey and a complaint investigation conducted at your facility on 10/22/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The facility was licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 8. Eight resident files were reviewed and 7 employee files were reviewed. One discharged resident file was reviewed. Complaint # NV 17201 was unsubstantiated. Complaint # NV 18921 was unsubstantiated. The following deficiencies were identified:	Y 000		
Y 002 SS=F	449.179(1)(b) & (c) Licensing-BLC Remodel Approval NAC 449.179 1. Except for a residential facility with less than 11 beds, before a residential facility is constructed or an existing facility is remodeled, the facility must: (a) Submit the plan for construction or remodeling to the entity designated to review such plans by	Y 002		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 002	Continued From page 1 the Health Division pursuant to the provisions of NAC 449.0115. (b) Notify the Bureau of a tentative date for the completion of the construction or remodeling; and (c) Obtain approval of the plan from the Health Division. This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to submit plans for replacement or renovation of the septic tank system to be reviewed by the Health District. Findings include: On 10/27/08, an investigation was conducted to determine the functionality of the septic tank system of the facility. According to an interview with the owner on the morning of 10/27/08, a new septic tank system was just installed at the facility located in the front yard. The septic tank installation had been covered up by dirt at the time of the investigation. The toilets of the facility were tested and determined to have no backflow issues in the facility or at the front yard where the new septic tank was allegedly installed. The owner further indicated that he did not submit plans and or get a permit from the Southern Nevada Health District prior to the new installation of the septic tank system.	Y 002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 002	Continued From page 2 Severity: 2 Scope: 3	Y 002		
Y 051 SS=C	449.194(2) Administrator's Responsibilities-Designation NAC 449.194 The administrator of a residential facility shall: 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge. This Regulation is not met as evidenced by: Based on observation, and record review on 10/22/08, the administrator failed to designate one or more employees to be in charge of the facility during those times when the administrator was absent. Findings include: The facility failed to provide the current document	Y 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 051	Continued From page 3 designating the employee in charge during the absence of the administrator. Severity: 1 Scope: 3	Y 051		
Y 072 SS=E	449.196(3) Qualications of Caregiver-Med re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on interview and record review the facility failed to provide the training required pursuant to NRS 449.037 of at least 3 hours of training in the management of medication to the caregivers that were present. Findings include: Employee #5, #6 and #7 all stated that they were	Y 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 072	Continued From page 4 just "helping out" for the day. The facility failed to provide personnel files with the proof of medication training for 3 of 7 employees, (#5, #6 and #7). Severity: 2 Scope: 2	Y 072		
Y 085 SS=I	449.199(1) Staffing-CG on duty all times NAC 449.199 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. This Regulation is not met as evidenced by: Based on observation and interview on 10/22/08 the administrator failed to ensure there was at least 1 trained caregiver on the premises if 1 or more residents were present at the facility. Findings include: On 10/22/08 at 1:30 PM the surveyor arrived at the facility and the door was answered by Employee #5 who indicated the owner/caregiver (Employee #1) was not home. When asked what his position was, he stated " I'm a friend of the owner who helps out at the facility." Eight residents were on the premises. Employee #6, a relief non-employed caregiver,	Y 085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 085	Continued From page 5 and Employee #7, a cook, were working at the facility on 10/22/08 from 1:30 PM until 6:15 PM. Employee #5 stated the Employee #1 relieved him at 6:30 PM each night. Resident #1 stated Employee #5 worked most days and Employee #1 came home each evening. Severity: 3 Scope: 3	Y 085		
Y 175 SS=I	449.209(4)(b) Health and Sanitation-Hazards NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility. This Regulation is not met as evidenced by: Based on observation and interview on 10/22/2008, the facility was not free of hazards. Findings include: On 10/22/2008 at 2:35 PM within 10 feet of the front door, in the front yard of the facility, an open ditch was observed that was about 20 feet long and 4 feet deep with exposed PVC pipes. No raw sewage or smell was noted in the ditch or the yard. Employee #5 indicated, the septic tank had backed-up and the workman on site were repairing the lines and septic tank. In bedroom's #2's bathroom a mop and bucket was observed in the shower. Bedroom #1 had a strong urine odor.	Y 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 175	Continued From page 6 Severity: 3 Scope: 3	Y 175		
Y 273 SS=E	449.2175(4) Service of Food - Special Diets NAC 449.2175 4. A resident who has been placed on a special diet by a physician or dietitian must be provided a meal that complies with the diet. The administrator of the facility shall ensure that records of any modification to the menu to accommodate for special diets prescribed by a physician or dietitian are kept on file for at least 90 days. This Regulation is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a special diet be provided for a resident as prescribed by the physicians for 3 of 8 residents (resident #2, #4 and #7), and that records of any modification to the menu were kept on file for at least 90 days. Findings include: Employee #6 confirmed that resident #2, #4 and #7 were not being served a diet as ordered by their physicians. Employee #6 further indicated residents #2, #4 amd #7 were eating "what everyone else eats". The file for resident #2 had a physician's order for a 2 GM Sodium, mechanical soft diet. The file for resident #4 had a physician's order for a low fat diet. The file for resident #7 had a physician's order for	Y 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 273	Continued From page 7 an 1800 calorie diabetic diet. There was no documented evidence that indicated the facility provided a meal plan that complied with the aforementioned diets. Severity: 2 Scope: 2	Y 273		
Y 434 SS=F	449.229(3) Emergency Drills NAC 449.229 3. A drill for evacuation must be performed monthly on an irregular schedule, and a written record of each drill must be kept on file at the facility for not less than 12 months after the drill. This Regulation is not met as evidenced by: Based on observation, the facility failed to ensure a drill for evacuation was performed monthly. Findings include: The facility lacked documented evidence of monthly fire drills, performed at the facility. The fire evacuation drill log was requested of Employee #5. Employee #5 called Employee #1 and reported there was no fire evacuation drill logs. Severity: 2 Scope: 3	Y 434		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 444	Continued From page 8	Y 444		
Y 444 SS=F	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility. This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke detectors were tested monthly. Findings include: The facility lacked documented evidence of monthly smoke detector test. The smoke detector test log was requested of Employee #5. Employee #5 called Employee #1 and reported there was no smoke detector logs. Severity: 2 Scope: 3	Y 444		
Y 645 SS=D	449.2704(1) Rate Agreement NAC 449.2704 The administrator of a residential facility shall, upon request, make the following information available in writing: 1. The basic rate for the services provided by the facility.	Y 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 645	Continued From page 9 This Regulation is not met as evidenced by: Based on record review the basic rate for the services provided by the facility was not provided for 3 of 8 residents. Findings include: The file for resident #4, (admitted 7/19/07), failed to have a rate agreement signed by the administrator and resident. The file for resident #5, (admitted 1/16/08), failed to have a rate agreement signed by the resident. The file for resident #6, (admitted 5/13/08), failed to have a rate agreement signed by the administrator and resident. Severity: 1 Scope: 2	Y 645		
Y 698 SS=F	449.2712(2)(b)(5) Oxygen-Tanks secured to wall or racks NAC 449.2712 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (b) Ensure that: (5) All oxygen tanks kept in the facility are secured in a stand or to a wall.	Y 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 698	Continued From page 10 This Regulation is not met as evidenced by: Based on observation on 10/22/08, the facility failed to ensure all oxygen tanks were secured in a rack or to the wall. Findings include: During an initial tour of the facility, 9 of 11 oxygen tanks were observed not secured to the wall or in a storage rack in the unlocked storage closet under the staircase #2. Severity: 2 Scope: 3	Y 698		
Y 721 SS=D	449.2716(1)(b) Colostomy / Ileostomy NAC 449.2716 1. A person who has a colostomy or ileostomy must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (b) The care for the colostomy or ileostomy is provided by a medical professional who is trained to provide that care. This Regulation is not met as evidenced by: Based on interview and record review the facility failed to ensure that the resident's colostomy was cared for by a medical professional who was trained to provide the care. Findings include:	Y 721		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 721	Continued From page 11 Resident #2's file indicated that she had a permenent colostomy. When asked how resident #2 had her colostomy taken care of, Employee #6 stated "I help with the colostomy care". . Severity: 2 Scope: 1	Y 721		
Y 830 SS=D	WAIVERS 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734 , inclusive. This Regulation is not met as evidenced by: Based on record review the administrator failed to submit the required paperwork requesting a waiver to care for a person receiving Hospice care for 1 of 8 residents (#3). Findings include:	Y 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 830	Continued From page 12 Resident #3 - Admission 9-04-08 The resident's file provided evidence the resident was receiving hospice care at the facility. There was no documented evidence the Administrator applied for a Hospice Waiver for this resident. . Severity: 2 Scope: 1	Y 830		
Y 859 SS=F	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. This Regulation is not met as evidenced by: Based on record review on 10/22/08, the facility failed to ensure that 4 of 8 residents received a physical examination prior to admission or annually. (#3, #4, #6 and #7). Findings include: Resident #3 (admitted 9/04/08), #6 (admitted 5/13/08) and #7 (admitted 9/27/07) failed to have documentation of an admission physical exam in their files.	Y 859		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 859	Continued From page 13 Resident #4 (admitted 7/19/07) and #7 (admitted 9/27/07) failed to have documentation of an annual physical exam in their files. Severity: 2 Scope: 3	Y 859		
Y 870 SS=F	449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication Administration NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. This Regulation is not met as evidenced by: Based on record review on 10/24/08, the facility failed to ensure that medication profile reviews were performed by a physician, pharmacist or registered nurse at least once every six months for 4 of 8 residents residing in the facility for longer than six months. Findings include:	Y 870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 870	Continued From page 14 Resident #2 was admitted to the facility on 6/18/07. There was no medication profile review available in the resident's record. Resident #4 was admitted to the facility on 7/19/07 . There was no medication profile review available in the resident's record. Resident #5 was admitted to the facility on 1/16/08 . The last medication profile review available in the resident's record was on 1/21/08. Resident #7 was admitted to the facility on 9/27/08. There was no medication profile review available in the resident's record. Severity: 2 Scope: 3	Y 870		
Y 876 SS=C	449.2742(4) NRS 449.037 NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met. This Regulation is not met as evidenced by: Based on record review on 10/22/08, the facility failed to obtain an ultimate user agreement authorizing the facility to administer medications to 5 of 8 residents, (#4, #5, #6, #7, and #8). Findings include:	Y 876		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 876	Continued From page 15 The files for resident #4; #5; #6; #7 and #8 lacked evidence of a signed ultimate user agreement authorizing the facility to administer medications to the residents. Severity: 1 Scope: 3	Y 876		
Y 896 SS=F	449.2744(1)(b)(2) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (2) The date and time that the medication was administered. This Regulation is not met as evidenced by: Based on record review the facility failed to record the medication administered to 8 of 8 residents and the date and time the medications were administered. Findings include: The medication administration records (MAR) of 8 of 8 residents were not initialed after Sunday, October 19, 2008 on any of the resident's MARs . Severity: 2 Scope: 3	Y 896		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 920	Continued From page 16	Y 920		
Y 920 SS=F	449.2748(1) Medication Storage NAC 449.2748 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. This Regulation is not met as evidenced by: Based on observation the facility failed to ensure that the residents medications were stored in a locked area. Findings include: The kitchen cupboard that stored the residents medications was observed unlocked upon initial arrival in the facility and throughout the survey. An unlabeled bottle of over-the-counter cough	Y 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 920	Continued From page 17 suppressant was noted to be out on an open shelf in the kitchen. Severity: 2 Scope: 3	Y 920		
Y 930 SS=F	449.2749(1)(a) Resident File NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (a) The full name, address, date of birth and social security number of the resident. This Regulation is not met as evidenced by: Based on observation and interview the facility failed to ensure the files of 8 of 8 residents were locked in a fire resistant place (#1, #2, #3, #4; #5, #6, #7 & #8). The facility failed to ensure discharged resident files were maintained for at least 5 years. Findings include: During the facility tour the files for Residents #1, #2, #3, #4, #5, #6, #7 & #8 were observed on a shelf in a unlocked room off the kitchen. The facility failed to maintain a file on a resident discharged within the past year. Employee # 5 had no recollection of Resident #10, a discharged	Y 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 930	Continued From page 18 resident and failed to locate resident's file. Severity: 2 Scope: 3	Y 930		
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 10/22/08, the facility failed to ensure residents had received the required tuberculosis (TB) screening test for 6 of 8 residents (#1, #2, #4, #5, #6 and #7). Findings include: Resident #1's file, (admission date 6/26/07) lacked documented evidence of an annual one-step TB screening test. Resident #2's file, (admission date 6/18/07) lacked documented evidence of a two-step TB screening test upon admission, and an annual one-step TB screening test. Resident #4's file, (admission date 7/19/07)	Y 936		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Continued From page 19 contained documentation the resident completed only the first step of the required two-step TB screening test on 6/01/06. The file lacked documented evidence indicating the resident had completed the second step, or had the annual TB screening test for 2008. Resident #5's file, (admission date 1/16/08) lacked documented evidence of a two-step TB screening test upon admission. Resident #6's file, (admission date 5/13/08)lacked documented evidence of a two-step TB screening test upon admission. Resident #7's file, (admission date 9/27/07) lacked documented evidence of an annual one-step TB screening test. Repeat deficiency from survey dated 12/07/2007. Severity: 2 Scope: 3	Y 936		
Y 938 SS=F	449.2749(1)(g)(1) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief	Y 938		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 938	Continued From page 20 description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident. This Regulation is not met as evidenced by: Based on record review on 10/22/08, the facility failed to perform an evaluation on 1 of 8 residents for their abilities to perform the activities of daily living (ADL) upon admission to the facility, or an annual evaluation of a resident's ability to perform the activities of daily living on 4 of 8 residents residing in the facility longer than a year. Findings include: Resident #6's, (admission date 5/13/08), file lacked documented evidence of an ADL assessment upon admission to the facility. Resident #2's, (admission date 6/18/07) file lacked documented evidence of an annual ADL assessment. Resident #4's, (admission date 7/19/07) file lacked documented evidence of an annual ADL assessment. Resident #7's, (admission date 9/27/07) file lacked documented evidence of an annual ADL assessment. Resident #8's, (admission date 6/16/07) file lacked documented evidence of an annual ADL assessment.	Y 938		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 938	Continued From page 21 Severity: 2 Scope: 3	Y 938		
Y 969 SS=F	449.2754(5)(c)(3) Alzheimer's Policies NAC 449.2754 5. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (c) A description of: (3) The manner in which the behavioral problems will be managed. This Regulation is not met as evidenced by: Based on observation, record review and interview 10/22/08, the administrator of an Alzheimer's endorsed facility failed to maintain a policy on how behavorial problems will be managed. Findings include: The facility lacked a posted policy on wandering and other behavorial problems. There was a notification document in 9 of 9 resident's files that stated in paragraph 3 "This facility cannot assume responsibility if the resident is in need of or requires skilled nursing services or has a dementia process that may result in excessive wandering." The facility's policies and procedures were requested from Employee #5. Employee #5	Y 969		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 969	Continued From page 22 called Employee #1 and reported there was no policy and procedure book. Severity: 2 Scope: 3	Y 969		
Y 991 SS=I	449.2756(1)(b) Alzheimer's Fac door alarm NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. This Regulation is not met as evidenced by: Based on observation the facility failed to ensure operational alarms, or other audible devices are activated when an exit door is opened at the facility. Findings include: The surveyor observed on 10/22/08 at 2:30 PM the alarm was turned off on the front door to the facility. Outside the front door to the facility there was an open ditch that was about 20 feet long and 4 feet deep with exposed PVC pipes. During an outside tour of the facility, it was observed the south rear exit to the facility had the alarm disabled. Severity: 3 Scope: 3	Y 991		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 992 SS=F	449.2756(1)(c) Alzheimer's Fac awake staff NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. This Regulation is not met as evidenced by: Based on observation and interview the facility failed to ensure at least 1 member of the staff was awake and on duty at the facility at all times. Findings include: An interview with Employee #6 revealed the night caregiver slept in a resident's room downstairs. Employee #1 slept in the living quarters upstairs during the night. If a resident rang a bell, located in each resident's room, the caregiver would wake up and respond to the resident's need. Severity: 2 Scope: 3	Y 992		
Y 995 SS=F	449.2756(1)(f)(1) Alzheimer's Facility yard NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor	Y 995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 995	Continued From page 24 activities; All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times. This Regulation is not met as evidenced by: Based on observation, the administrator of the facility providing care to Alzheimer's disease failed to ensure all gates leading from the fenced area to an open area were locked. Findings include: On 10/22/08 at 1:30 PM, the left and right electronic driveway gates did not meet in the center. This created a 3 foot open gap between the gates. On 10/22/08 at 6:15 PM the driveway gates were completely open with no staff supervision in the area. Severity: 2 Scope: 3	Y 995		
Y 999 SS=F	449.2754(1)(g) Alzheimer's Facility NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (g) All toxic substances are not accessible to the	Y 999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 999	Continued From page 25 residents of the facility. This Regulation is not met as evidenced by: Based on observation, the facility failed to ensure all toxic substances were not accessible to the residents. Findings include: Unsecured bleach next to the toilet adjoining bedroom 1 was observed. Zinc oxide ointment, shampoo, body wash, and mouthwash was observed in an unlocked storage cabinet under staircase #2. In the designated smoking area inside the garage, spray paint, barbecue starter fluid, and WD-40 was observed on a shelf 36 inches from the ground. In an unlocked cabinet in the garage bottles of bleach were also observed. Repeat deficiency from survey dated 06/13/2007. Severity: 2 Scope: 3	Y 999		
YA101 SS=E	449.200(1)(a-f)Personnel Files NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his employment at the residential facility;	YA101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
YA101	Continued From page 26 (c) Records relating to the training received by the employee; (d) The health certificates required pursuant to chapter 441 of NAC for the employee; (e) Evidence that the references supplied by the employee were checked by the residential facility; and (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to provide a complete personal file for 3 of 7 employees (#5, #6 & #7). Findings include: Employee #5 There was no separate file available for Employee #5. The following items were not available at the time of the survey. The employee's name, address, telephone number, social security number, proof of age, date of employment, training records, the results of a physical examination, initial 2-step tuberculin screening or other TB screens, fingerprints, criminal history background checks, first aid and cardiopulmonary resuscitation (CPR) certificates. Employee #6 There was no separate file available for Employee #6. The following items were not available at the time of the survey. The employee's name, address, telephone number,	YA101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
YA101	Continued From page 27 social security number, proof of age, date of employment, training records, the results of a physical examination, initial 2-step tuberculin screening or other TB screens, fingerprints, criminal history background checks, first aid and cardiopulmonary resuscitation (CPR) certificates. Employee #7 There was no separate file available for Employee #7. The following items were not available at the time of the survey. The employee's name, address, telephone number, social security number, proof of age, date of employment, training records, the results of a physical examination, initial 2-step tuberculin screening or other TB screens, fingerprints, criminal history background checks, first aid and cardiopulmonary resuscitation (CPR) certificates. Severity: 2 Scope: 2	YA101		
YA922 SS=F	449.2748(3)(a,b) Medication Labeling NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered.	YA922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4787AGC	A. BUILDING _____ B. WING _____	10/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME 2	3045 SOUTH TIOGA WAY LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
YA922	Continued From page 28 This Regulation is not met as evidenced by: Based on observation and record review the medications were not kept in their original containers until administered. Findings include: On 10/22/08 at 4:30 PM, medications for 8 of 8 residents were observed in plastic medication boxes. Eight (8) of eight (8) residents had an AM and PM plastic medication boxes (med minders) in their medication bins. The med minder compartments labeled Sunday through Wednesday AM were empty. Pills were observed in the Wednesday PM compartment of the med minders and for the rest of the week, Thursday - Saturday of 8 of 8 residents. Severity: 2 Scope: 3	YA922		